STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION

IN RE: Maxim Healthcare Services, Inc. of East Hartford, CT
111 Founders Plaza, Suite 103
East Hartford, CT 06198

CONSENT ORDER

WHEREAS, Maxim Healthcare Services, Inc. (hereinafter the "Licensee"), has been issued License No. 0004 to operate a Home Health Care Agency, (hereinafter the "Facility") under Connecticut General Statutes 19a-490 by the Department of Public Health, State of Connecticut (hereinafter the "Department"); and

WHEREAS, the Facility Licensing and Investigations Section (hereinafter the "FLIS") of the Department conducted unannounced inspections on various dates commencing on January 28, 2009 and concluding on February 4, 2009 with additional information received through February 11, 2009; and

WHEREAS, the Department, during the course of the aforementioned inspections identified violations of the Connecticut General Statutes and/or Regulations of Connecticut State Agencies in a violation letter dated February 18, 2009 (Exhibit A – copy attached); and

WHEREAS, the Licensee is willing to enter into this Consent Order and agrees to the conditions set forth herein.

NOW THEREFORE, the FLIS of the Department acting herein and through Joan Leavitt its Section Chief, and the Licensee, acting herein and through Brian Wynne, its President, hereby stipulate and agree as follows:

1. Effective upon the execution of this Consent Order, the Licensee, through its Governing Body, Administrator and Supervisor of Clinical Services, shall ensure substantial compliance with the following:
    a. Care for patients shall be provided in accordance with an individual patient plan of care established by the physician;

b. Patient treatments, therapies and medications are administered and documented as prescribed by the physician and in accordance with each resident's comprehensive care plan;

c. Medication responses are assessed, all profiles are complete and, if applicable, discrepancies are clarified with the physician in a timely manner;

d. Patient assessments and/or re-assessments are performed in a timely, accurate and comprehensive manner and accurately reflect the condition of the patient;

e. Each patient care plan is reviewed and revised to reflect the individual patient's problems, needs and goals, based upon the patient assessment and in accordance with applicable federal and state laws and regulations;

f. The personal physician or covering physician is notified in a timely manner of any significant changes in the patient's condition including, but not limited to deterioration of mental and physical status; and

g. All care provided by licensed practical nurses shall be under the direction and supervision of a registered nurse.

2. The Licensee shall within fourteen (14) days of the effective date of this Consent Order and/or in accordance with the Facility's plan of correction, review or develop and/or revise all policies and procedures as necessary, which are pertinent to patient assessment; the plan of care; medication administration; and notification of the physician of a change in the condition and/or status of the patient.

3. The Licensee shall within twenty-one (21) days of the effective date of this Consent Order, review and revise as necessary, each patient's plan of care based upon the patient's current and ongoing assessments.

4. The Licensee shall within thirty (30) days of the effective date of this Consent Order and/or in accordance with the Facility's plan of correction, in-service all direct service staff on topics relevant to the provisions of Sections 1, 2 and 3 of this document. The Licensee shall maintain an attendance roster of all in-service presentations that shall be available to the Department for a period of two (2) years.

5. The Licensee shall, institute into it's evaluation of staff competency a mechanism whereby the Supervisor of Clinical Services shall quarterly conduct joint home visits with each primary care nurse ("PCN"), as well as a clinical record audit of twenty (20) percent of the PCN's current caseload, to assess clinical competence and to initiate a program of remediation, as applicable. A report of the program's onsite competency

evaluations and record audits shall be presented to the Professional Advisory Committee four times per year. Said reports shall be available for review by the Department for a period of two (2) years.

6. Supervisors of Clinical Services shall be responsible for ensuring that all care provided to patients by all caregivers is in accordance with individual comprehensive care plans. All Supervisors of Clinical Services shall be supervised and monitored by a representative of the Licensee's administrative/corporate clinical staff to ensure the Supervisors of Clinical Services are functioning in accordance with this Consent Order and state and federal requirements. Records of such administrative visits and supervision shall be retained for the Department's review.
7. The Licensee, within seven (7) days of the execution of this document, shall designate an individual within the Facility to monitor the requirements of this Consent Order. The name of the designated individual shall be provided to the Department within said timeframe. The assigned individual shall submit monthly reports to the Department regarding the provisions contained within this document.
8. The Licensee's Administrator, and the Supervisors of Clinical Services shall meet with the Department every four (4) weeks for the first three (3) months after the effective date of this Consent Order and thereafter at twelve (12) week intervals for the following six (6) months. The meetings shall include discussions of issues related to the care and services provided by the Licensee.
9. The Licensee shall ensure that the established quarterly Clinical Record Review program to review patient care issues includes those identified in the February 18, 2009 violation letter. Minutes of the QAP/Clinical Record Review meetings shall be kept for a minimum of three (3) years and made available for review upon request of the Department.
10. For the duration of this Consent Order, Maxim Healthcare Services, Inc. shall petition the Department for approval to open any additional patient service office(s) and/or to apply for any new Home Health Care Agency license in the State of Connecticut.
11. In accordance with Connecticut General Statutes Section 19a-494(a)(5), the license of Maxim Healthcare Services, Inc. is placed on probation for a period of the term of this Consent Order.
12. The Licensee shall pay a monetary penalty to the Department in the amount of seven thousand dollars ($7,000.00), by money order or bank check payable to the Treasurer of

the State of Connecticut and mailed to the Department within (2) weeks of the effective date of this Consent Order. The money penalty and any reports required by this document shall be directed to:

Victoria V. Carlson, RN, MBA
Supervising Nurse Consultant
Facility Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, P.O. Box 340308 MS #12HSR
Hartford, CT 06134-0308

13. All parties agree that this Consent Order is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of the Consent Order or of any other statutory or regulatory requirements, which may be sought in lieu of or in addition to the methods of relief listed above, or any other administrative and judicial relief provided by law. This Consent Order may be admitted by the Department as evidence in any proceeding between the Department and the Licensee in which compliance with its terms is at issue. The Licensee retains all of its rights under applicable law.
14. The execution of this document has no bearing on any criminal liability without the written consent of the Director of the MFCU or the Bureau Chief of the Department of Criminal Justice's Statewide Prosecution Bureau.
15. The terms of this Consent Order shall remain in effect for a period of two (2) years from the effective date of this document unless otherwise specified in this document.
16. The Licensee understands that this Consent Order and the terms set forth herein are not subject to reconsideration, collateral attack or judicial review under any form or in any forum including any right to review under the Uniform Administrative Procedure Act, Chapter 368a of the Statutes, Regulations that exists at the time the agreement is executed or may become available in the future, provided that this stipulation shall not deprive the Licensee of any other rights that it may have under the laws of the State of Connecticut or of the United States.
17. The Licensee had the opportunity to consult with an attorney prior to the execution of this Consent Order.

*

WITNESS WHEREOF, the parties hereto have caused this Consent Order to be executed by their respective officers and officials, which Consent Order is to be effective as of the later of the two dates noted below.

MAXIM HEALTHCARE SERVICES,
INC OF EAST HARTFORD, CT - LICENSEE

4/7/09
Date

By: _____
Brian Wynne, President

STATE OF Maryland)

County of Howard) ss _____ 2009

Personally appeared the above named Brian Wynne and made oath to the truth of the statements contained herein.

My Commission Expires: 08/28/2010
(If Notary Public)

ELSA G. FLORES
NOTARY PUBLIC STATE OF MARYLAND
My Commission Expires August 28, 2010

_____
Notary Public [✓]
Justice of the Peace [ ]
Town Clerk [ ]
Commissioner of the Superior Court [ ]

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

4/9/09
Date

By: _____
Joan D. Leavitt, R.N., M.S., Section Chief
Facility Licensing and Investigations Section

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT A
PAGE 1 OF 10

February 18, 2009

Kathleen Kingston, RN, Administrator
Maxim Healthcare Services, Inc
333 East River Drive, Suite 110
East Hartford, CT 06108

Dear Ms. Kingston:

Unannounced visits were made to Maxim Healthcare Services, Inc on January 28, February 3, 4, 2009 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation with additional information received through February 11, 2009.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

An office conference has been scheduled for March 5, 2009 at 1:00PM in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish legal representation, please feel free to have an attorney accompany you to this meeting.

Please prepare a written Plan of Correction for the above mentioned violations to be presented at this conference.

Each violation must be addressed with a prospective Plan of Correction which includes the following components:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).
2. Date corrective measure will be effected.
3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

We do not anticipate making any practitioner referrals at this time.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Victoria V. Carlson

Victoria V. Carlson, RN, MBA
Supervising Nurse Consultant
Facility Licensing and Investigations Section

SNC:NC:

c. Complaint # CT 9179

Phone: (860) 509-7400
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HSR
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

DATE(S) OF VISIT: January 28, February 3, 4, 2009 with additional information received through February 11, 2009

EXHIBIT A

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section D68(b)(4)(A) General requirements.

1. The Governing authority failed to assume responsibility for the quality of services provided by the agency and to ensure the safety and quality of care rendered to Patient #s 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 14, 15, and 16 as evidenced by the violations listed in this document.

The following is a violation of the Regulations of Connecticut State Agencies Section D68(d)(2) General requirements.

2. The administrator failed to organize and direct the agency's ongoing functions and to ensure the safety and quality of care rendered to Patient #s 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 14, 15, and 16 as evidenced by the violations listed in this document.

The following is a violation of the Regulations of Connecticut State Agencies Section D68 (e)(2)(3)(A)(B)(C) General requirements.

3. The supervisor of clinical services failed to assume responsibility for coordinating, managing and/or maintaining the quality of clinical services rendered to patients and families by direct service staff and/or failed to effectively supervise the clinical competence of assigned nursing personnel and/or failed to directly evaluate the clinical competence of assigned nursing personnel as evidenced by the care and services rendered to Patient #1 as evidenced by the violations listed in this document.

The following is a violation of the Regulations of Connecticut State Agencies Section D69(a)(3)(A) Services and/or D74(a) Administration of medicines.

4. Based on clinical record review, agency policy review and interviews with primary caregiver, physical therapist and agency personnel it was determined that for ten (10) of sixteen (16) patients (Patient #s 1, 2, 3, 4, 5, 6, 7, 8, 9, 10) the registered nurse failed to initiate the plan of care and necessary revisions. The findings include:

a. For Patient #s 1, 2, 3, 4, 5, 6, 7, 8 and 9 all with a start of care date of 1/15/09 the plans of care dated 1/15/09 stated that the agency would provide skilled nursing care up to 32 hours weekly, but failed to include accurate visit frequency for each patient. When interviewed on 1/29/09 the SCS stated that frequency of nursing visits was determined by staff availability and the physician was not contacted to discuss specific frequencies for each patient prior to providing care.
Review of the "physician's supplemental orders" (unsigned and undated), the plans of care, medication administration records and/or the medication profiles for Patient #s 1, 2, 3, 4, 5, 6, 7, 8 and 9 for the

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

period from 1/15/09 to 1/25/09 identified that discrepancies were documented for drugs and/or treatments ordered and/or administered in the varying documents. Documentation was lacking of clarification with the physician of the appropriate orders and/or notification of the physician in a timely manner that drugs and/or treatments were not carried out.
Agency policy review determined that when referrals are not from a physician, the patient's physician will be contacted to confirm service needs and to obtain verbal orders and/or that the nurse would review the medication regime and verify that the ordered schedule of medications is being followed.
When interviewed on 1/28/09 the SCS stated that for these patients a non-professional person copied the initial medication/treatment lists from the previous home health agency's record that were then transcribed by a clerical person at the agency. The SCS did not validate the medications and/or treatments with the physician prior to providing care.

b. Patient #10's start of care date was 12/16/08. Diagnoses included viral pneumonia, esophageal reflux, congenital heart anomaly and cleft palate. The care plan dated 12/16/08 ordered RN every 30 days to assess and supervise care plan, private duty skilled nursing 8-16 hours daily up to 96-hours weekly for complete assessment and required care/interventions for nutrition/hydration via G-tube with aspiration precautions, respiratory function with tracheostomy, pulmonary suction, pain control and response to pain relief measures, medication administration as needed. An interagency referral (W-10) report dated 12/16/09 ordered Bactrim, Miralax and Spironolactone. The plan of care dated 12/16/09 failed to include these medications, but included Prevacid, Miconozole and Lorazepam that were not on the W-10 dated 12/16/09. The medication profile dated 12/16/09 included Bactrim, but lacked Miralax and Spironolactone. There was no documentation in the clinical record that the physician was contacted prior to starting care to verify medications and/or there were no MARs for that period to identify the specific medications that were administered by agency nurses.
Review of agency policy determined that medications must be documented on the plan of treatment, the medication profile and the MAR and/or when two physicians are ordering similar and/or interacting medications, the nurse will consult with the primary physician for clarification.
When interviewed on 2/3/09 the SCS stated that the physician was not contacted at the start of care to clarify medications and/or treatments and no agency person monitors that MARs accurately reflect administration of ordered medications.
On 2/4/09 the SCS gave the surveyor MARs dated from 12/16/08 to 1/17/09 and stated that the MARs were created that day by LPN #3 to identify medications that LPN #3 administered from 12/16/09 to 1/17/09. LPN #3 identified that Bactrim and Spironolactone were given as ordered on the W-10 dated 12/16/09; Prevacid, and Miconozole were given as ordered on the plan of care dated 12/16/09, Lorazepam was discontinued and there was no documentation that Miralax was given . The SCS stated that the nurse might have been informed about these drugs by the caregivers, but failed to obtain supplemental orders. The registered nurse failed to initiate the plan of care and necessary revisions prior to the start of care.

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THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section D69(a)(3)(D) Services and/or D74(b) Administration of medicines.

5. Based on clinical record review, review of agency policies and staff interview it was determined that for Patient #1 agency nurses failed to assess and/or failed to document assessment of the patient's status that suggested a need to alter the plan of care and/or to promptly inform the physician of the patient's changed status. The findings include:

a. Patient #1's start of care date was 1/15/09. Diagnoses included quadriplegia, severe mental retardation and cerebral palsy. The plan of care dated 1/15/09 ordered private duty nurse up to 32-hours per week for total care needs including observation and recording of all seizure activity to include precipitating event, occurrence of aura, duration, type of movements, changes in level of conscious, and to notify the physician with change in seizure activity and/or neurological changes. H-HHA was ordered up to 45-hours per week for personal care. Review of a medication list, undated, unsigned and transcribed onto a "Supplementary Physician's Order" form indicated that medication orders included Phenobarbital 60 mg twice daily. The certification plan of care, the medication administration record (MAR) and the medication profile failed to include Phenobarbital. Documentation on the OASIS/comprehensive assessment by RN #1 identified that the patient had history of seizures, but there was no documentation of a baseline assessment of intensity, frequency and/or duration of seizures. During the period from 1/20/09 to 1/23/09 agency nurses identified the onset of seizure activity that escalated in frequency and duration. During the night of 1/22-23/09 LPN #1 identified that sixteen (16) seizures occurred that lasted from 30 seconds to 5 minutes, temperature was 102.6 and there were new abrasions on the on the right abdomen, flank and elbow. During the period from 1/20/09 to the morning of 1/23/09 agency nurses identified that seizure medications were administered as ordered.
Review of agency policy determined that the patient's response to medication is monitored in accordance with the patient's clinical needs and/or that the physician will be contacted within 24-hours or sooner for changes in the patient's condition.
During the period from 1/20/09 through the night of 1/22-23/09 there was no documentation to indicate that agency nurses intervened to address the onset of seizures of intensified frequency and duration while the patient was taking anti-convulsant medications and/or that agency nurses collaborated with the physician regarding the patient's diminished response to ordered anticonvulsant medications and/or the patient's changed status.
On 1/23/09 an unsigned nurse's flow sheet identified that the PCG called the neurologist and when the call was returned the nurse updated the physician. The nurse identified that no care plan changes were ordered. On 1/23/09 on the evening shift, RN #1 identified that seizures occurred twice and the temperature continued to be elevated. On 1/24/09 RN #1 identified that the PCG called for emergency care due to ongoing seizures.
When interviewed on 1/29/09 the primary care giver (PCG) stated that agency nurses did not call the physician, and so she called the neurologist after the repeated seizures during the night of 1/22-23/09. The physician ordered additional doses of Keppra and Motrin and the phone was given to LPN #2 to take the order. During the night of 1/23-24/09 the agency failed to fill the evening shift and the PCG

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

was alone with the patient and seizures continued. On the morning of 1/24/09 the patient was admitted to the intensive care unit secondary to ongoing seizures, elevated temperature and aspiration of emesis and required intubation and ventilator assist for respiratory function. The PCG stated that during the night of 1/23-24/09 she realized that Phenobarbital had not been given by agency nurses since 1/15/09 and that she suspected that Keppra was under dosed because the order was not written clearly on the agency's MAR.
When interviewed on 1/29/09 the primary physician (pediatrician) stated that he did not know that the patient was having seizures and/or that the patient was admitted to hospital.
Agency nurses failed to accurately evaluate and/or to accurately document the patient's ordered medications, the patient's intensifying seizure activity while taking anti-convulsant medications and/or failed to collaborate with the physician in a timely manner about the patient's changed status that suggested a need to alter the plan of care.

The following is a violation of the Regulations of Connecticut State Agencies Section D69(a)(4) Services.

6. Based on clinical record review, personnel record review and staff interview, it was determined that for Patient #1 the LPN failed to appropriately administer medications. The findings include:

a. Patient #1's start of care date was 1/15/09. The certification plan of care dated 1/15/09 ordered Keppra 500 mg, three tablets twice daily. Documentation in the clinical record indicated that LPN #1 on 1/20/09, 1/21/09 and 1/2309 gave this medication.
When interviewed on 1/28/09 the SCS stated that LPN #1 told her on 1/24/09 that she did not review the order completely and/or daily sign the MAR when she administered the Keppra. LPN #1 told the SCS that she only administered Keppra 500 mg each day, but did not realize the dose ordered was 1500 mg twice daily until she signed the MAR at the end of the week.

The following is a violation of the Regulations of Connecticut State Agencies Section D73(b) Patient care plan.

7. Based on clinical record review, agency policy review and staff interviews it was determined that for eight (8) of sixteen (16) patients (Patient #s 2, 3, 4, 5, 6, 7, 8, 9) the agency failed to establish a written plan of care with a physician to provide services. The findings include:

a. For Patient #s 2, 3, 4, 5, 6, 7, 8 and 9 all with a start of care date was 1/15/09, there was no documentation to support that the agency reviewed the plan with the physician and/or that verbal orders were obtained prior to starting care.
b. On 1/28/09 the Supervisor of Clinical Services (SCS) stated that Patient #s 2, 3, 4, 5, 6, 7, 8 and 9 were transferred from another home health agency. The coordinator of the former agency's physical

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therapy office prepared the plans of care using the medication/treatment lists that were copied from the former agency's care plans. In response to surveyor inquiry the SCS stated that the agency had not contacted the physician to obtain validation of the medications and/or treatments and/or to obtain verbal orders prior to starting care.

c. Review of agency policy determined that if a referral for services were not from a physician, the patient's physician would be contacted to confirm service needs and to obtain verbal orders. The agency provided services prior to receiving verbal and/or written orders from the physician to accurately identify the patient's health care needs.

The following is a violation of the Regulations of Connecticut State Agencies Section D73(b) Patient care plan.

8. Based on clinical record review, agency policy and staff interviews it was determined that for Patient #2 the agency failed to inform the physician of changes in the patient's condition that suggested a need to alter the plan of care. The findings include:

a. Patient #2's start of care date was 1/15/09. Diagnoses included quadriplegia, severe mental retardation, cerebral palsy, asthma, esophageal reflux and seizures. The plan of care dated 1/15/09, signed by the physician on 1/23/09 ordered private duty nurse up to 32 hours weekly for total care needs including observation of all seizure activity to include precipitating event, occurrence of aura, duration, type of movements, changes in level of conscious, and to notify the physician with change in seizure activity and/or neurological changes. No seizure activity was documented for Patient #2 until 1/22/09 when RN #1 identified that the patient had a seizure. There was no documentation to indicate that the SCS and/or RN #1 informed the physician about the seizure.

The following is a violation of the Regulations of Connecticut State Agencies Section D74(a)(1) Administration of medicines.

9. Based on clinical record reviews, policies and procedures and agency staff interview it was determined that for seven (7) of sixteen (16) patients (Patient #s 2, 3, 4, 5, 6, 10, 15) agency professional staff failed to provide drugs and/or treatments only as ordered by the physician. The findings include:

a. Patient #2's start of care date was 1/15/09. A note by the SCS dated 1/24/09 identified that she informed RN #1 that an order for Phenobarbitol had not been transcribed onto the medication administration record.
When interviewed on 1/29/09 the SCS stated that on 1/24/09 the PT called to state that the patient should be getting Phenobarbitol, but it was not on the medication administration record (MAR) and the

EXHIBIT A

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

patient had a seizure on 1/22/09.
Documentation of medications administered by agency nurses on MARs dated 1/15/09 through 1/24/09 failed to include Loratadine. An incident report by the SCS dated 1/26/09 identified that the physician was informed on 1/26/09 that Phenobarbitol was not given from January 16, 2009 through January 23, 2009, but there was no documentation to support that the physician was informed of the missed doses of Loratadine.

b. Patient #3's start of care date was 1/15/09. The certification plan of care dated 1/15/09 ordered Vitamin C, Fish Oil, Respiridone, Prevacid, Glycerin, Acidopholous, Multivitamins, Canola Oil, Dimatapp, Ventolin, Acetaminophen, Ibuprofen, Bacitracin, Nystatin Ointment, Lotrimin, Robitussin, Fleet enema and Pedialyte.
The medication administration records dated 1/16/09 to 1/24/09 failed to include Acidophilous. A written statement by the SCS (undated) given to the surveyor on 2/3/09 identified that from 1/16/09 to 1/24/09 Acidophilus was not administered by agency nurses as ordered by the physician.

c. Patient #4's start of care date was 1/15/09. The plan of care dated 1/15/09 ordered skilled nurse up to 32 hours weekly for total care. Orders included 23 medications and oxygen. During the period from 1/15/09 to 1/25/09 agency nurses identified that tube feedings were administered every two hours, however there was no documentation of physician's orders for tube feedings.
When interviewed on 2/3/09 the SCS stated that the family probably informed the nurse about the tube feedings and the nurse forgot to get physician's orders.

d. Patient #5's start of care date was 1/15/09. Diagnoses included spina bifida with hydrocephalus, depressive disorder, obstructive hydrocephalus, acute nephritis and hip dislocation. The plan of care dated 1/15/09 failed to include Acidophillus and/or Vitamin C, but documentation by agency nurses on the MARs dated 1/15/09 to 1/24/09 identified that these medications were administered daily.

e. Patient #6's start of care date was 1/15/09. The plan of care dated 1/15/09 ordered Fleet enema daily. During the period from 1/15/09 to 1/25/09 there was no clinical record documentation to indicate that the enemas were given. A "supplemental physician's order "unsigned and undated listed Simethicone 125 mg two tabs in water via G tube daily at 6pm, but this was not verified with the physician prior to providing care. The plan of care dated 1/15/09 that was signed by the physician on 1/23/09 ordered Simethicone 125 mg via tube in water daily. Documentation by agency nurses on the MAR from 1/18/09 through 1/22/09 indicated that Simethicone 125 mg was given.

f. Patient #10's start of care date was 12/16/08. Diagnoses included viral pneumonia, esophageal reflux, congenital heart anomaly and cleft palate.
The care plan dated 12/16/08 ordered private duty skilled nursing 8-16 hours daily for complete assessment and required care/interventions for nutrition/hydration via G-tube with aspiration precautions, respiratory function with tracheostomy, pulmonary suction, pain control and response to pain relief measures and medication administration. An interagency referral (W-10) report dated

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

12/16/08 ordered Diuril, Budesonide, Lansoprazole, Glycopyrrolate, Albuterol, Bactrim, Miralax and Spironolactone. The plan of care dated 12/16/08 failed to include Bactrim, Miralax and Spironolactone. Documentation on MARs dated 12/16/08 to 1/17/09 identified that LPN #3 revisited Monday through Friday each week and administered Bactrim and Spironolactone.
When interviewed on 2/5/09 the patient's mother stated that she thought the nurse was giving the Bactrim, Miralax and Spironolactone daily.
When interviewed on 2/3/09 the SCS stated the agency did not obtain orders for the Bactrim, Miralax and/or Spironolactone at the start of care. On 2/4/09 the SCS gave the surveyor a copy of a supplemental order dated 2/4/09 by an APRN that included Bactrim, Miralax and Sprionolactone.

g. Patient #15's start of care date was 1/9/09. Diagnoses included cerebral artery occlusion, type II diabetes and hypertension. The plan of care dated 1/9/09 ordered skilled nurse 3 times per week for general assessment, manage medication regime/compliance and to pre-pour medications. Ordered medications included Cefuroxime Axetil, Prednisone, Plavix, Protonix, Fosomax, Lisinopril, Aspirin, Carisoprodol and Lanuts Insulin, but no specific dose of Lantus Insulin was ordered. There was no documentation of collaboration with the physician and/or of a supplemental order to clarify the Lantus Insulin dose. During the period from 1/9/09 to 1/21/09 RN #3 identified that Lantus 30 units was pre-filled for the patient to self- administer.
When interviewed on 2/3/09 the SCS stated that the nurse forgot to obtain an order for the Lantus Insulin.
Review of agency policy determined that medications must be ordered by the physician prior to administration.

The following is a violation of the Regulations of Connecticut State Agencies Section D74(b) Administration of medicines.

10. Based on clinical record review and staff interview it was determined that for seven (7) of sixteen (16) patients (Patient #s 2, 5, 6, 7, 14, 15, 16) the registered nurse failed to complete a comprehensive assessment that included a review of all the medications the patient was currently using and/or to clarify discrepancies with the physician.
The findings include:

a. Patient #2's start of care date was 1/15/09. The plan of care dated 1/15/09 ordered 34 medications. Review of a medication list, undated, unsigned and transcribed onto a "Supplementary Physician's Order" form indicated that medication orders included Phenobarbital 60 mg twice daily and Loratadine 10 mg tablet daily. The certification plan of care and the medication administration record failed to include Phenobarbital and Loratadine.
b. Patient #5's start of care date was 1/15/09. Review of a medication list, undated, unsigned and transcribed onto a "Supplementary Physician's Order" form indicated that medication orders included Acidophillus and Vitamin C. There was no documentation to indicate that these medications were

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

verified with the physician and they were not included on the certification plan of care dated 1/15/09.

c. Patient #6's start of care date was 1/15/09. Review of an undated, unsigned "Supplementary Physician's Order" form indicated that medication orders included Diastat 20 mg Acudial, one per rectum as needed for seizures greater that 15 minutes, Dimetapp Elixer 10 ml via G-tube every four hours as needed and Simethicone 125 mg two tabs via G-tube every 6 hours as needed. There was no documentation to indicate that these medications were verified with the physician prior to starting care. The plan of care, the medication administration record and the medication profile dated 1/15/09 ordered Diastat Acudial one per rectum as needed for seizures greater than 15 minutes, Dimetapp Elixer 5 ml via G-tube three times daily as needed and Simethicone 125 mg via G-tube daily.

d. Patient #7's start of care date was 1/15/09. Review of a medication list, undated, unsigned and transcribed onto a "Supplementary Physician's Order" form indicated that medication orders included Robitussin DM Liquid, give 10cc every four hours as needed for cough and cold symptoms The plan of care and medication administration record dated 1/15/09 failed to include Robitussin.

e. Patient #14's start of care date was 12/23/08. Diagnoses included hypertension, hyperlipidemia, anxiety and angina. A supplemental physician's order dated 12/23/08 ordered skilled nurse weekly to assess cardiopulmonary status and pre-pour medications. Ordered medications included Isorbide, Furosemide, Vitamin C, Simvastatin, Metoprolol, Alprazolam, Multi-vitamin and Meclizine. The plan of treatment dated 12/23/08 ordered these same medications, but there was no order for the Meclizine. The medication profile dated 12/23/08 by RN #4 included all of the medications as ordered on the supplemental order dated 12/23/09. The MAR failed to include the Meclizine. During the period from 1/4/09 to 2/1/09 RN #4 identified that she pre-poured Isorbide, Furosemide, Vitamin C, Simvastatin, Metoprolol, and Multi-vitamins for one week, but that the patient self administered the Alprazolam. There was no documentation to indicate that the patient was taking and/or receiving Meclizine.

f. Patient #15's start of care date was 1/9/09. Diagnoses included cerebral artery occlusion, type II diabetes and hypertension. The plan of care dated 1/9/09 ordered skilled nurse skilled nurse 3 times per week for general assessment, manage medication regime/compliance and to pre-pour medications. Ordered medications included Cefuroxime Axetil, Prednisone, Plavix, Protonix, Fosomax, Lisinopril, Aspirin, Carisoprodol and Lanuts Insulin, but no specific dose of Lantus Insulin was ordered. There was no documentation of collaboration with the physician and/or of a supplemental order to clarify the Lantus Insulin dose prior the start of care and/or when the nurse pre-filled the syringe with Lantus Insulin 30 u for the patient to self-administer.

g. Patient #16's start of care date was 12/10/08. Diagnoses included brain anomaly, hypothyroidism, hypoglycemia and epilepsy. The plan of care dated 12/10/08 ordered skilled nurse "24/7" for complete assessment, management of all health care needs including oro-pharangeal suction, g-tube care and feedings and medication administration. Scheduled medication orders on the plan of care included Pulmicort, Flonase, Keppra, Poly-vitamin, Miralax, Tegretol, Reglan, Zantac, Levothyroxine, Clonazepam, Phenobrabital, Genotropin, Hydrocortisone Sodium and Cortef (2.5mg BID and 5mg qd);

EXHIBIT A

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

as needed medications included Ibuprophen, Albuteral, Atrovent and Acetominophen.
The medication profile by RN #3 dated 12/19/08 and MARs dated 12/10/08 to 1/17/09 identified these same medications, however the MARs included Cortef 7.5 mg three times daily as needed for temperature greater than 101 that was not included on the plan of treatment and/or the medication profile. Documentation was lacking of clarification with the physician of the as needed dose of Cortef.

h. Agency policy determined that medications must be documented on the plan of treatment, the medication profile and the MAR and that physician's orders are to be obtained prior to medication administration.
When interviewed on 1/28/09 the SCS stated that she reviewed the medications as transcribed onto the plans of care for Patient #s 2, 5, 6, 7 by clerical staff, but did not obtain a list of the medications from the patient's physician.